U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 11 March 2005

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In the Matter of:

ORLAND PARKS,
Claimant,

v. **Case No. 2003-BLA-06580**

CLINCHFIELD COAL CO./
PITTSTON CO.,
Employer/Carrier, and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-In-Interest.

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Appearances:

Andrew Delph, Esq., Wolfe, Williamson and Rutherford, Norton, VA
For Claimant

Timothy W. Gresham, Esq., Penn, Stuart & Eskridge, Abingdon, VA
For Employer/Carrier

Before: PAMELA LAKES WOOD
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §901, *et. seq.* (hereafter "the Act") filed by Claimant Orland Parks ("Claimant") on April 18, 2002. The instant claim is the third claim filed by the Claimant; however, the first claim was withdrawn. The putative responsible operator is Clinchfield Coal Company ("Employer").

Part 718 of title 20 of the Code of Federal Regulations is applicable to this claim, as it was filed after March 31, 1980, and the regulations amended as of December 20, 2000 are also

applicable, as this claim was filed after January 19, 2001.[1] 20 C.F.R. §718.2. In *National Mining Assn. v. Dept. of Labor,* 292 F.3d 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit rejected the challenge to, and upheld, the amended regulations with the exception of several sections.[2] The Department of Labor amended the regulations on December 15, 2003 for the purpose of complying with the Court's ruling. 68 Fed. Reg. 69929 (Dec. 15, 2003).

The findings of fact and conclusions of law hereafter are based upon my analysis of the entire record, including all evidence admitted and arguments submitted by the parties. Where pertinent, I have made credibility determinations concerning the evidence.

STATEMENT OF THE CASE

Claimant's first claim was filed on July 6, 1987, and it was later withdrawn on August 10, 1988 by the request of the Claimant. (DX1).

Claimant filed a second application for benefits on January 7, 1999 and it was denied on August 2, 1999. (DX2). The denial was premised upon the District Director's finding that Claimant was not totally disabled due to pneumoconiosis. *Id.*

Claimant filed the instant claim on April 18, 2002. (DX4). The District Director issued an October 23, 2002 Schedule for the Submission of Additional Evidence, which indicated that Claimant would not be entitled to benefits based on the initial evidence and that Clinchfield Coal Company was the responsible operator. (DX23). On a preliminary basis, the District Director's office concluded that the evidence indicated that the Claimant worked as a coal miner for 31 years, that Claimant had pneumoconiosis, and that the Claimant's pneumoconiosis was caused at least in part by exposure to coal mine dust. *Id.* However, the initial evidence did not support a finding that the Claimant was totally disabled and the totally disabling impairment was caused at least in part by pneumoconiosis. *Id.* On May 15, 2003, the Proposed Decision and Order issued by the District Director denied benefits on the basis that the evidence did not show that the miner had pneumoconiosis, that the disease was caused in part by coal mine employment, and that the miner was totally disabled. (DX35). Claimant requested a formal hearing, and the case was transmitted to the Office of Administrative Law Judges on September 2, 2003 for a hearing. (DX41).

A hearing in the above-captioned matter was held on March 2, 2004 in Abingdon, Virginia. At the hearing, Director's Exhibits 1 through 42 ("DX1" through "DX42"), Claimant's Exhibit 1 ("CX1"), and Employer's Exhibits 1 through 7 ("EX1" through "EX7") were admitted into evidence. (Tr. at 5-10). There were no witnesses to testify and the parties agreed to have a hearing on the record. At the conclusion of the proceedings, the record was kept open for 45 days for the submission of rehabilitative evidence relating to Employer's Exhibit No. 5 (Dr. Scatarige's reading of a November 20, 2003 x-ray). (Tr. at 10, 13). Thereafter, the parties were given 30 days to submit briefs or closing arguments. *Id*. No rehabilitation evidence was

[1] Section and part references appearing herein are to Title 20 of the Code of Federal Regulations unless otherwise indicated.

[2] Several sections were found to be impermissibly retroactive and one which attempted to effect an unauthorized cost shifting was not upheld by the court.

submitted. Employer submitted a joint request on behalf on both parties for an extension of the briefing deadline until June 16, 2004. Based upon such request, I accept both parties' briefs, submitted on June 22, 2002, as timely.

By letter of June 25, 2004, Employer objected to Claimant's reference to the January 6, 2003 medical report by Dr. Rasmussen and the pulmonary function test results, arterial blood gases, and x-ray reading by Dr. Patel of the same date and requested that references to the report and associated clinical data be excluded from Claimant's closing argument. The January 6, 2003 medical report is not a part of the record and will not be considered. Therefore, the request that the references to the report in the Claimant's closing argument be stricken is **GRANTED**, and the record is now closed. **SO ORDERED.**

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Issues/Stipulations

The issues before me are the existence of pneumoconiosis, its causal relationship to coal mine employment, total disability, and causation of total disability. (DX 42, Tr. at 6). The employer stipulated to 31 years of coal mine employment. *Id.*

Medical Evidence

The newly submitted medical evidence consists of the following:

X-Ray ILO Readings [3]	**Pulmonary Function Studies**	**Arterial Blood Gas Studies**	**Medical Examination Reports**
June 4, 2002, (DX14), J. Forehand, B-Reader, positive 1/2, p/s, 4 zones	June 4, 2002 (DX14) (Nonqualifying)	June 4, 2002 (DX14) (Qualifying-rest; Non-Qualifying-exercise)	June 4, 2002 by Dr. Forehand (DX14)
June 4, 2002, (DX15), Peter Barrett, B-Reader & BCR, (quality only), quality 1	February 3, 2003 (DX33) (Nonqualifying)	February 3, 2003 (DX33) (Qualifying-at rest/exercise)	February 3, 2003 by Dr. Hippensteel (DX33; EX7 [deposition])
June 4, 2002, (DX32), John Scatarige, B-Reader & BCR, Negative, quality 2	November 20, 2003 (CX1) (Nonqualifying)	November 20, 2003 (CX1) (Qualifying- at rest/exercise)	November 20, 2003 by Dr. Rasmussen (CX1)

[3] Only x-ray readings in compliance with the regulations, using the ILO system, are included in this table.

February 3, 2003, (DX33), Paul Wheeler, B-Reader & BCR, Negative for pneumoconiosis, other findings, quality 2	February 4, 2004 (EX1) (Nonqualifying)	February 4, 2004 (EX1) (Qualifying- at rest/exercise)	February 4, 2004 by Dr. McSharry (EX1; EX6 [deposition])
November 20, 2003 (CX1), Manu Patel, B-reader &BCR, Pneumoconiosis 1/2, s/t, 6 zones, quality 1			
November 20, 2003 (EX5), J. Scatarige, B-Reader & BCR, Negative for pneumoconiosis, other findings, quality 1.			
February 4, 2004 (EX1), Paul Wheeler, B-Reader & BCR, Negative for pneumoconiosis, other findings, quality 2.			

In addition to the above, medical and hospital records, including x-ray and CT scan reports, were submitted. (DX33).

Evidence developed in connection with the prior (1999) claim includes the report of a Department of Labor examination conducted by Dr. Forehand on February 18, 1999 and associated test results. (DX 3). This evidence may be taken into consideration under 20 C.F.R. §725.309(d)(1). Employer also submitted rebuttal evidence relating to this claim. (EX4, x-ray reading by Dr. Scatarige for February 18, 1999 x-ray). However, evidence from the 1987 claim (DX 1) will not be reviewed as that claim was withdrawn and is considered not to have been filed under 20 C.F.R. §725.306(b).

Background and Employment History

Claimant was born in 1931 and is currently seventy four years old. (DX4). His wife, Jerline, is his only dependent, and Employer has not contested her dependency. (DX4, 41). Claimant began working in the coal mining industry in 1957, and he estimated that he worked in underground coal mining for 33 years. (DX6). Claimant's coal mining employment began with Clinchfield Coal Company on June 21, 1957, and (apart from two periods totaling approximately two years and four months) he worked for the same company until January 31, 1991, when he retired. (DX2, 6, 9, 10). At the hearing, the Employer stipulated to 31 years of coal mining experience and I so find. (Tr. at 6).

While employed at Clinchfield Coal Company, Claimant worked as a repairman, mechanic, electrician, and welder. (DX6, 9). He fixed machinery, checked belt drives and did electrical work. (DX6). As a part of his job duties, he was frequently required to lift and carry tools, motors and oxygen tanks weighing 50 pounds. *Id.* In addition, he lifted welding equipment, such as torches and other equipment. *Id.*

Claimant stated in his 2002 application for benefits that he experienced shortness of breath. (DX4). Also, he told Dr. Rasmussen that he began to experience shortness of breath during exertion some 25 years ago, and he presently becomes significantly short of breath after climbing a flight of stairs. (CX1). He wheezes mostly with exertion, and he sleeps on an elevated bed and sometimes awakens due to shortness of breath. *Id.* Dr. Forehand recorded similar findings. (DX14).

There is conflicting evidence in the record concerning the Claimant's smoking history. Both Drs. Rasmussen and Hippensteel noted that he smoked one half packs of cigarettes per day. (CX1, DX33). However, Dr. Rasmussen gave a smoking history dating from 1956 to 2002, when Claimant switched to a pipe, while Dr. Hippensteel recorded 10 years of cigarette smoking followed by 15 to 20 years of pipe smoking. *Id.* In his June 2002 examination report, Dr. Forehand noted that Claimant had smoked four cigarettes per day since 1972 and also chewed tobacco. (DX14). However, in 1999, he recorded a history of one pack per day from 1968 to 1998. (DX2). Dr. McSharry stated that Claimant smoked one pack a day for 25 years. (EX1). The February 2004 pulmonary function test report noted that the patient stated he smoked "on and off for years" and now smoked a pipe. (EX 1). Claimant is obviously an unreliable historian, giving an account of sporadic cigarette smoking that ranged from 5 pack years to 30 pack years. Based upon 30 years of smoking at approximately one half pack per day, I find that 15 pack years is a reasonable estimate.

Discussion

To prevail in a claim for Black Lung benefits, a claimant must establish that he or she suffers from pneumoconiosis; that the pneumoconiosis arose out of coal mine employment; that he or she is totally disabled, as defined in section 718.204; and that the total disability is due to pneumoconiosis. 20 C.F.R. §§718.202 to 718.204. The Supreme Court has made it clear that the burden of proof in a black lung claim lies with the claimant, and if the evidence is evenly balanced, the claimant must lose. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 281 (1994). In *Director, OWCP v. Greenwich Collieries*, the Court invalidated the "true doubt" rule, which gave the benefit of the doubt to claimants. *See Id.* Thus, in order to prevail in a black lung case, a claimant must establish each element by a preponderance of the evidence.

Subsequent Claim Requirements

The instant case is a subsequent claim, because it was filed more than one year after the first denial of benefits in 1999. *See* §725.309(d). Previously, such a claim would be denied based upon the prior denial unless the claimant could establish a material change in conditions. *See* 20 C.F.R. §725.309(d). The Fourth Circuit Court of Appeals held that a claimant must prove, by a preponderance of the evidence developed subsequent to the denial of the prior claim,

at least one of the elements adjudicated against him in the prior denial. *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358 (4th Cir. 1996) (en banc).

The amended regulations have replaced the material-change-in-conditions standard with the following standard:

> (d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see §725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. **A subsequent claim** shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim **shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement** (see §§725.202(d) (miner), 725.212 (spouse), 725.218 (child), and 725.222 (parent, brother, or sister)) **has changed since the date upon which the order denying the prior claim became final.**[4] The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
> (1) Any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
> (2) For purposes of this section, **the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based.** For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.
> (3) **If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement.** . .
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see § 725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim. . . .[Emphasis added.]

[4] For a miner, the conditions of entitlement include whether the individual (1) is a miner as defined in the section; (2) has met the requirements for entitlement to benefits by establishing pneumoconiosis, its causal relationship to coal mine employment, total disability, and contribution by the pneumoconiosis to the total disability; and (3) has filed a claim for benefits in accordance with this part. 20 C.F.R. §725.202(d) *Conditions of entitlement: miner.*

20 C.F.R. § 725.309(d) (2003). Thus, it is necessary to look at the new evidence relating to each medical condition of entitlement to determine whether it establishes that condition of entitlement.

The prior claim was denied based upon the failure to establish total disability. (DX2). Thus, I must first determine whether the new evidence establishes that the Claimant is totally disabled.

Subsequent Claim: Total Disability

The regulations as amended provide that a claimant can establish total disability by showing pneumoconiosis prevented the miner "[f]rom performing his or her usual coal mine work," and "[f]rom engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." 20 C.F.R. §718.204(b)(1). Where, as here, there is no evidence of complicated pneumoconiosis, total disability may be established by pulmonary function tests, arterial blood gas tests, evidence of cor pulmonale with right sided congestive heart failure, or physicians' reasoned medical opinions, based on medically acceptable clinical and laboratory diagnostic techniques, to the effect that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in the miner's previous coal mine employment or comparable work. 20 C.F.R. §718.204(b)(2). For a living miner's claim, it may not be established solely by the miner's testimony or statements. 20 C.F.R. §718.204(d)(5).

Claimant's last coal mine employment of at least one year was with Clinchfield Coal Company as a repairman, electrician, and welder. (DX6). While employed at Clinchfield, he fixed machinery, checked belt drives, and performed electrical work also. *Id.* He was also required to lift and carry tool bags, motors, oxygen tanks, and welding equipment weighing 50 pounds. *Id*. I find, based upon the newly submitted evidence, Claimant lacks the pulmonary or respiratory capacity to perform his last or usual coal mine work and has established total disability under §718.204(b)(2).

Pulmonary function tests. Claimant has not established total disability through qualifying pulmonary function tests. Under subparagraph (i) of section 718.204(b)(2), total disability is established if the FEV1 value is equal to or less than the values set forth in the pertinent tables in 20 C.F.R. Part 718, Appendix B, for the miner's age, sex and height, if in addition, the tests reveal qualifying FVC or MVV values under the tables, or an FEV1/FVC ratio of less than 55%. The pulmonary function tests produced the following pre-bronchodilator and post-bronchodilator values:

Date	**Exhibit No.**	**FEV1** (pre/post)	**FVC** (pre/post)	**MVV** (pre/post)	**FEV1/FVC** (pre/post)
6/4/02	DX 14	2.18	3.94	76	55
2/3/03	DX 33	2.15/2.06	3.79/3.38	91	57/61
2/4/04	EX1	2.21/2.17	3.86/3.8	102	74/74

11/20/03	CX1	2.25/2.38	4.01/4.26	Not Listed	56/56

None of the new pulmonary function tests produced qualifying values for the Claimant's age (70 and 71) and recorded height (69 inches) as all of the FEV1 values are nonqualifying. *See* 20 C.F.R. §718.204(b)(2)(i); Part 718, Appendix B. Accordingly, I find that the pulmonary function tests do not support a finding of total disability under §718.204(b)(2)(i).

Arterial blood gases. Claimant has satisfied the burden of proving total disability through arterial blood gas studies under §718.204(b)(2)(ii). The four newly submitted arterial blood gas ("ABG") studies produced the following values (rest/exercise):

Date	**Exhibit No.**	**PCO2** (rest/exercise)	**PO2** (rest/exercise)
6/4/02	DX14	38/38	56/68 (terminated after 3 minutes due to fatigue)
2/3/03	DX33	37.6/35.7	57.8/46.8 (terminated after 1 minute, 32 seconds due to dyspnea)
11/20/03	CX1	37/38	57/51 (exercised 7 minutes)
2/4/04	EX1	37/38	58/48 (exercised 8 minutes, 47 seconds)

All of the above results, with the exception of the June 4, 2002 results (during exercise), produced qualifying values under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix C. It is worth noting that two of the above tests were terminated prior to completion. Dr. Hippensteel noted that Claimant exercised for one minute and 32 seconds on February 3, 2003, and the test was stopped due to dyspnea. (DX33). In addition, while its results were validated, the June 4, 2002 test was stopped after three minutes due to fatigue. (DX14). I find that the Claimant's inability to complete such test weighs heavily in the favor of proving disability, because if the Claimant is unable to complete an abbreviated treadmill exercise then it is highly unlikely that he would be able to work as a repairman/welder lifting tools, motors, welding equipment, and oxygen tanks for at least eight hours per day.

Employer raised an interesting argument that the contrary probative evidence discredits the qualifying arterial blood gas studies by showing that the Claimant's disability is cardiovascular and not respiratory or pulmonary in nature. *Employer's Brief* at 10. In this regard, the regulations state that "in the absence of contrary probative evidence," total disability can be proven by one of the four paragraphs (b)(2)(i), (ii), (iii), or (iv). If there is contrary evidence in the record, all evidence must be weighed as a whole to determine whether there is proof by a preponderance of the evidence that the miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.,* 9 B.L.R. 1-195 (1986). In this case, there is contrary probative evidence in the medical reports of Drs. Forehand, Hippensteel, and McSharry. Dr. Forehand's report stated that the resting hypoxemia arose from unspecified nonpulmonary causes. (DX14). Dr. Hippensteel stated that Claimant's gas exchange impairment did not appear to be associated with a pulmonary or respiratory condition and opined that it was related to the Claimant's cardiovascular condition. (DX33). And, the report of Dr. McSharry stated that although the ABG studies met the Department of Labor's standard for disability, the hypoxemia was not explained

by any known cardiac or pulmonary abnormalities. (EX1). Although this evidence is relevant with respect to the interpretation of the significance of the ABG studies, it does not negate the qualifying values shown on the majority of the tests. It will be considered further in the discussion of the medical opinion evidence. Moreover, I find that the evidence relied upon by Employer is most relevant to a discussion regarding causation of the disability (as discussed below).

Despite the June 4, 2002 (during exercise) non-qualifying results, I find that the remaining studies that showed qualifying values during exercise satisfy the preponderance of the evidence standard. It is also worth noting that the last test administered in February 2004 produced qualifying exercise values, a matter of significance given the progressive nature of pneumoconiosis. Accordingly, I find that the arterial blood gas studies support a finding of total disability. Based upon consideration of all the evidence, I find that Claimant has satisfied section 718.204(b)(2)(ii).

Cor pulmonale with right-sided congestive heart failure. There is no evidence of cor pulmonale, so Claimant has not established total disability under section 718.204(b)(2)(iii).

Medical opinion evidence on total disability. Claimant has established total disability through reasoned medical opinions. Where total disability cannot be shown under paragraphs (b)(2)(i), (ii), or (iii) of this section, or where pulmonary function tests and/or blood gas studies are medially contraindicated, total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory findings, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment or comparable work. §718.204(b)(2)(iv). The following physicians provided medical opinions addressing the issue of whether Claimant is totally disabled by a pulmonary or respiratory condition:

- J. Randolph Forehand, M.D., conducted the Department of Labor examination on June 4, 2002. (DX14).
- Kirk E. Hippensteel, M.D., examined Claimant and prepared a report on February 3, 2003 at the Employer's request. (DX 33). He also had his deposition taken on February 20, 2004. (EX7).
- D.L. Rasmussen, M.D., examined Claimant and prepared a report on November 20, 2003 at the Claimant's request. (CX1).
- Roger J. McSharry, M.D., examined Claimant and prepared a report on behalf of Employer on February 4, 2004. (EX1). He also had his deposition taken on February 13, 2004. (EX6).

First, I will consider the medical reports submitted by these experts:

(1) J. Randolph Forehand, who is the director of pulmonary studies at Southern Appalachian Center for pulmonary studies and holds specializations in pediatrics, allergy and immunology, and is board eligible in pediatric pulmonary medicine, conducted an examination of Claimant on June 4, 2002. A summary of the Claimant's work history, medical history, and family history was noted in the report, together with detailed physical findings. Dr. Forehand

found the x-ray readings consistent with coal worker's pneumoconiosis ("CWP"), ventilatory studies revealed obstructive ventilatory pattern, arterial blood gas studies showed no hypoxemia with exercise, and EKG showed no acute changes. The cardiopulmonary diagnosis was CWP and pulmonary nodule, and the etiology of the diagnosis was "coal dust exposure, rule out malignancy." On the issue of Impairment, he concluded:

> A respiratory impairment exists. Sufficient residual ventilatory and oxygen transfer capacities remain to continue working in last coal mining job. Resting hypoxemia arose from [unspecified] nonpulmonary causes.

In the section of the form asking the extent to which each of the cardiopulmonary diagnoses contributed to the impairment, he stated: "Coal workers' pneumoconiosis is the sole cause of respiratory impairment." (DX 14).

(2) Kirk E. Hippensteel, M.D., who is board-certified in internal medicine and the subspecialty of pulmonary diseases, conducted a physical examination of Claimant on February 3, 2003 at the request of the Employer/Carrier. He provided a detailed summary of the Claimant's work description, smoking history, and present breathing condition. Additionally, he reviewed and summarized various medical reports. The physical examination revealed that his lungs had a few rales in the right base that cleared with deep breathing, and he had minimal wheezes. His heart rhythm was regular with no S3 gallop or murmur.

The test results revealed the following:

- Chest x-ray interpreted by Dr. Wheeler revealed 0/0 reading with subtle decrease in markings in central portion of right upper lobe.
- The spirometry shows mild airflow obstruction pre and post bronchodilator. Claimant's MVV was mildly reduced with very small tidal volumes. No restriction was present, and the diffusion was in the low normal range.
- Arterial blood gases showed hypoxemia at rest; and during exercise, the hypoxemia worsened.
- His electrocardiogram showed normal sinus rhythm with left anterior conduction block.

Dr. Hippensteel "agree[d] with Dr. Forehand's conclusion that [Claimant] does not have enough permanent pulmonary impairment from any cause to keep him from going back to work at his regular job in the mines" due to the variability of his gas exchange impairment. He concluded that the Claimant's gas exchange impairment does not appear to be associated with pulmonary or diffusion impairment as a cause for this gas exchange impairment. He stated that the impairment relates to Claimant's cardiac output and arteriosclerotic disease with a reasonable degree of medical certainty, even though he was not exercised to a high enough level to show definite ischemia. He stated that the continued smoking resulted in the elevation of carboxyhemoglobin levels, which also has a mild effect on gas exchange impairment. He further stated that all findings suggest a mild obstructive impairment secondary to his smoking and not referable to CWP in this case. (DX 33).

(3) D. L. Rasmussen, M.D., who is board certified in internal medicine, conducted a physical examination of Claimant on November 20, 2003 at the Claimant's request. The report summarized the Claimant's medical history, smoking history, family history, and occupational history. In connection with the occupational history, he noted that the Claimant was employed in the coal mining industry for a total of 32 1/2 years, working principally as a mechanic and welder underground, and that he carried heavy tools weighing between 50 to 70 pounds.

The results from the physical examination revealed that the chest expansion was normal with moderately to markedly reduced breath sounds. There were bilateral fine inspiratory crackles but no murmurs, gallops, or clicks. The chest x-ray by Dr. Patel, which indicated pneumoconiosis s/t with a profusion of 1/2 throughout all lung zones, was considered by Dr. Rasmussen. The laboratory studies revealed minimal, irreversible obstructive ventilatory impairment, the single breath carbon monoxide diffusing capacity was moderately reduced, there was moderate resting hypoxia, there was marked impairment in oxygen transfer on exercise, and he was markedly hypoxic during exercise. From these results, Dr. Rasmussen concluded that the Claimant had a marked loss of lung function, and he lacked the pulmonary capacity to perform his last regular coal mine job.

Dr. Rasmussen relied upon the significant history of exposure to occupational dust and x-ray changes consistent with pneumoconiosis in finding that Claimant had CWP which arose from his coal mine employment. He further noted that both cigarette smoking and coal dust exposure contributed to the lung tissue destruction, citing epidemiological studies in support. However, he found that the coal mine dust exposure caused additional damage, which may result in causing increased impairment in oxygen transfer even without airway obstruction. In support, he cited to his own studies of coal miners. He concluded that the Claimant's coal mine dust exposure was the major cause of his disabling lung disease. (CX1).

(4) Roger J. McSharry, M.D., who is board certified in internal medicine, pulmonary medicine, and critical care medicine, examined the Claimant, reviewed the medical report by Dr. Rasmussen and offered a medical opinion dated February 4, 2004. A history including the occupational, medical, family and social history were included in the report. He found the chest excursion to be normal during the physical examination, and the breathing sounds were slightly diminished without wheezes, masses or bruits. He reached the following conclusions:

- There was insufficient evidence for a diagnosis of CWP. He stated that apparently many x-rays over the years were generally negative. He stated that s and t opacities may often represent pulmonary vasculature.
- He stated that the pulmonary function tests were not at all suggestive of CWP, and the trivial airflow obstruction and air trapping suggests mild obstructive lung disease common among long time smokers.
- The pulmonary function tests revealed mild respiratory impairment of purely obstructive nature.
- Significant hypoxemia was noted on blood gas studies, as documented previously. This meets Department of Labor standards for disability and has been shown to worsen with minimal exertion.

- The hypoxemia is not explained by any known cardiac or pulmonary abnormalities. Thus, further investigation is needed in order to classify it as a respiratory impairment.
- A variety of clinical conditions, such as pulmonary hypertension and pulmonary or systemic vasculitis, could cause these types of serious pulmonary problems. He stated that pulmonary hypertension is the suspected cause, although there is no specific diagnostic test identifying this. However, pulmonary hypertension due to underlying left ventricular failure or severe COPD is excluded in this case.
- He stated that the Claimant is disabled but the cause is not coal mine employment.
- He recommended additional testing to clarify the cause of the symptoms.

Factors to be considered when evaluating medical opinions include the reasoning employed by the physicians and the physicians' credentials. *See Millburn Colliery Co. v. Hicks,* 138 F.3d 524, 536 (4th Cir. 1998). A doctor's opinion that is both reasoned and documented, is supported by objective medical tests, and is consistent with all the documentation in the record, is entitled to greater probative weight. *See Fields v. Island Creek Coal Co.,* 10 B.L.R. 1-19 (1987).

Despite its inclusion of detailed physical findings and history, Dr. Forehand's overall report lacks adequate analysis to support his findings, which are stated in a conclusory manner. His finding that Claimant had sufficient residual ventilatory and oxygen transfer capacities to continue the last coal mining employment was based upon the nonqualifying pulmonary function tests and the improvement in arterial blood gases on exercise. However, the improvement that Dr. Forehand noted was not shown on the three remaining, more recent ABGs. It is unclear whether Dr. Forehand would have reached the same finding had he had the benefit of this more recent data. Moreover, the report failed to discuss the type of labor required as a repairman and welder or the lifting requirements of those jobs, and such considerations are important in determining whether Claimant has the capacity to perform the former job responsibilities. Therefore, Dr. Forehand's report has little probative value.

Dr. Hippensteel's report contained limited analysis, and the bulk of it was devoted to summarizing past medical records. Additionally, the discussion included in the report for the most part focused on the causation of total disability and provided minimal guidance on the issue of total pulmonary or respiratory disability. The only statement regarding total disability was that he agreed with Dr. Forehand's conclusion that Claimant is not totally disabled because his gas exchange impairment is variable. He failed to explain how variable gas exchange impairment impacted total disability. Thus, the report lacks reasoning to support his conclusion and is entitled to less weight.

Dr. Rasmussen's report provided some discussion on the issue of total disability. After explaining the testing results, he stated that the Claimant was unable to perform his last coal mine employment based on the studies that indicated a marked loss of lung function. However, he reported a number of clinical findings and failed to indicate which studies he was relying upon and how they supported his conclusions. Moreover, although he detailed the exertional requirements of Claimant's coal mine employment, a discussion on how the loss of lung function would impact the Claimant's ability to perform specific job functions is lacking. Nevertheless, it is clear that he determined that the minimal obstructive ventilatory impairment, the moderately

reduced diffusing capacity, the moderate resting hypoxia, and the marked hypoxia and impairment in oxygen transfer during exercise, resulted in total pulmonary disability. He concluded that the Claimant "does not retain the pulmonary capacity to perform his last regular coal mine job." His report is reasoned and documented.

The report of Dr. McSharry relating to the issue of total disability is also reasoned and documented. His finding of total disability was based on the significant hypoxemia, which meets the Department of Labor standards and worsened with minimal exertion. He discussed the requirements of the Claimant's employment but did not specify the lifting requirements. While the report lacked a discussion on how the examination findings and test results correlated with the physical requirements of the Claimant's job duties, I nevertheless find the report to have adequately addressed the issue of total disability. Dr. McSharry's report was based upon comprehensive data concerning Claimant's history and medical condition that was sufficient to support the conclusions reached.

Depositions were only taken of the two Employer's experts, Drs. Hippensteel and McSharry:

> **Dr. Hippensteel's Deposition:** Dr. Hippensteel began by stating his qualifications of board certifications in the area of pulmonary diseases, critical care and internal medicine. (EX7 at 5.) He testified that he examined the Claimant on February 3, 2003 and, since the time of his prior report, reviewed additional medical records. *Id.* at 6. Claimant's occupational history consisted of 31 and one half years in the mines and he last worked as an electrician and a mechanic, but he also welded and operated equipment, including a miner, a buggy, and a cutting machine, and he did extra work on occasion. *Id.* at 7. Most of his work was as a mechanic and required periodic heavy lifting of up to 200 pounds. *Id.* Dr. Hippensteel characterized this work as "periodic very heavy manual labor." *Id.*
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> He testified that the Claimant's carboxyhemoglobin level (3.9%) was consistent with smoking almost one pack of cigarettes per day but could be explained by the Claimant's history of smoking three pipefuls a day. *Id.* at 9. He stated that evidence of cardiac problems was shown in the January 10, 2002 echocardiogram, which showed a mild to moderate concentric left ventricular hypertrophy, but a cardiologist only found mild coronary artery changes. *Id.* at 11. There was no evidence of right-sided congestive heart failure or any right ventricular hypertrophy on the January 2002 echocardiogram. *Id.* at 13. Claimant had mild air flow obstruction, very mild air trapping with no evidence of restriction, and diffusion in the normal range, according to the pulmonary function test,. *Id.* at 17-19. Dr. Rasmussen found diffusion at 59 per cent of predicted, but he used Dr. Crapo's prediction formula, based upon a mostly Mormon population from Utah. *Id.* at 18. Dr. McSharry found diffusion of 84 per cent of predicted, which is in the "normal range." *Id.* at 19.
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> The arterial blood gases taken as part of Dr. Hippensteel's examination were abnormal and showed hypoxemia. *Id.* at 20. Abnormal blood gases may be caused by coal dust exposure, cigarette smoking or pipe smoking. *Id.* at 20. Dr. Hippensteel explained that pneumoconiosis interferes with diffusion in the lungs and results in the worsening of gas

exchange during exercise. *Id.* at 21-22. He opined that heart disease is the cause of the Claimant's impairment. *Id.* at 23. He further stated that the Claimant's heart disease altered the blood flow and extraction of oxygen in his extremities when he exercised, which caused the gas exchange impairment. *Id.* at 23-24. Moreover, he stated that smoking has not participated much in the decrease of the PO2 during exercise. *Id.* The disconnection between the gas exchange impairment and what the pulmonary function test showed makes heart disease the likely cause of the disability. *Id.* at 26-27.

Dr. Hippensteel also offered the opinion that Claimant does not suffer from coal workers' pneumoconiosis or any chronic lung disease related to coal dust exposure. *Id.* at 26. He stated that Claimant had minimal ventilatory impairment, diffusion was normal, and the gas exchange impairment was not lung related. *Id.* at 28. However, his final conclusion was that Claimant's impairment would prevent him from performing his last coal mining job. *Id.* He stated that the impairment was not caused by coal dust exposure. *Id.*

During cross examination, he further explained that the impairment was unrelated to his lungs but caused by cardiovascular problems. *Id.* at 31-32. He also stated that even if pneumoconiosis were not supported by x-ray findings, it should still produce diffusion impairment. *Id.* at 32.

Dr. Hippensteel's testimony is reasoned and provides support for some of his conclusions. However, on the issue of total disability, he does not rehabilitate the unreasoned medical report submitted but actually undermines his conclusions, because the deposition testimony is in conflict with the medical report submitted. In his medical report, he stated that he agreed with Dr. Forehand's conclusion that Claimant is not totally disabled because his gas exchange impairment is variable. (DX33). However, the deposition testimony clearly stated that Claimant was totally disabled based upon his arterial blood gases and he was unable to perform his last coal mine employment. (EX7 at 28.) He has provided no explanation for his changed opinion. Therefore, the opinion of Dr. Hippensteel is given very little weight on the issue of total disability.

Dr. McSharry's Deposition. He began by stating his qualifications, which included board certifications in the areas of internal medicine, pulmonary medicine, and critical care medicine. EX 6 at 4. He stated that he examined the Claimant on February 4, 2004 and subsequently reviewed some additional medical records. *Id.* at 4-5. Claimant provided a work history of more than 31 years of underground coal mining, primarily as a mechanic, but he did just about every job besides roof bolting. *Id.* at 5. Claimant described to him what a typical day involved. *Id.* At the time of the examination, he complained of shortness of breath primarily when exerting himself and he indicated that he could not climb hills and had difficulty with stairs. *Id.* at 6-7. He gave a smoking history of one pack per day for 25 years, quitting one year before in favor of a pipe; however, Dr. McSharry testified that the elevated carboxyhemoglobin level was consistent with one or two packs of cigarettes a day and was a little high for the two or three pipefuls of tobacco a day reported by the Claimant. *Id.* at 6-7.

Dr. McSharry stated that the exertional dyspnea could be explained by a number of conditions besides lung disease, including heart disease, being out of shape, overweight, and anemia, and the lack of chronic sputum production argues against chronic bronchitis. *Id.* at 7. An echocardiogram that he reviewed indicated that Claimant had left ventricular hypertrophy, which is associated with high blood pressure, but nothing else suggested significant heart disease. *Id.* at 8. In addition, he testified that the electrocardiogram done during his physical examination of the Claimant suggested a right ventricular hypertrophy and bundle branch block. *Id.* at 9.

The spirometry taken during his examination showed a very mild air flow limitation, a very mild air flow obstruction, and mild air trapping. *Id.* at 10-11. He further testified that the diffusion capacity (18.6) was normal on his test as compared with the expected value (22). *Id.* at 11-12. Dr. Rasmussen found 17.8, which Dr. McSharry also considered within the normal range, but Dr. Rasmussen used an expected value of 30. *Id.* at 12. Dr. McSharry explained that the predicted values by Dr. Crapo, which were used by Dr. Rasmussen, varied from the Morris-Polgar standard used by the Bristol hospital. *Id.* at 12-13.

When asked whether Claimant could do his last coal mine work base upon the arterial blood gases, he testified that based upon the Department of Labor standards, Claimant is disabled at rest, which "speaks for itself." *Id.* at 15. He also noted that the oxygenation declined with exercise to a point where he would not recommend that Claimant do strenuous work or moderately strenuous work. *Id.* These types of problems can be caused by smoking and coal workers' pneumoconiosis, but in either case one would expect to find problems on pulmonary function testing and particularly a lowered diffusion capacity. *Id.* at 16. He stated that based on the pulmonary function test alone, Claimant was not disabled. *Id.* at 21. Also, Claimant did not have cor pulmonale. *Id.* at 18. He stated that a number of diseases could be responsible for the low levels of oxygen and fairly normal lung tests, as seen in the Claimant's case. *Id.* at 17. However, he did not "have a good answer" as to which disease caused the Claimant's condition. *Id.* at 18.

Dr. McSharry opined that the Claimant did not have evidence of CWP or any other chronic lung disease which is related to or aggravated by his coal dust exposure. *Id.* at 20-21. He stated that Claimant suffered from arterial desaturation and the cause of such problem is unclear, and he further stated that this problem could arise when there is no history of coal dust exposure. *Id.* at 21-22. During cross-examination, he stated that smoking was not the cause of Claimant's totally-disabling hypoxemia. *Id.* at 24. Further, he stated that he had no opinion on the cause of the mild respiratory impairment shown on the pulmonary function test. *Id.*

The majority of the testimony was relevant to issue of causation. It generally echoed and expanded upon the points made by Dr. McSharry in his report and further discussed the requirements of Claimant's coal mine employment. Overall, I find that the deposition testimony adds additional weight to the medical report submitted by Dr. McSharry.

Considering all of the medical opinions, I find that the opinion of Dr. McSharry is the most well-documented and well-reasoned and is entitled to the most weight. *See Fields, supra*, (stating that a "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis, and that a "reasoned" opinion is one in which the underlying documentation is adequate to support the physician's conclusions). Further, I find that Dr. McSharry's report and deposition support a finding of total disability. In this regard, despite his suggestion that the respiratory impairment was mild and the disabling arterial blood gases are due to something other than a pulmonary or respiratory impairment, he has not really identified any basis for determining that the Claimant is totally disabled by anything other than a pulmonary or respiratory impairment. In essence, Dr. McSharry's opinion is that the Claimant has a totally disabling pulmonary or respiratory impairment, although it may be due to a nonpulmonary etiology. Dr. Hippensteel's opinion, as explained at his deposition, is consistent, although he has definitively identified another etiology (cardiovascular disease). Likewise, Dr. Rasmussen also found a total pulmonary or respiratory disability, although he attributed it to coal dust exposure and smoking. Dr. Forehand was the only physician to determine that the Claimant was not totally disabled. However, Dr. Forehand's finding that the Claimant retained sufficient residual ventilatory and oxygen transfer capacities to continue working at his last coal mining job was based upon the ABGs taken during his examination, which were inconsistent with the three later tests. I therefore find his opinion to be entitled to no weight. Thus, the medical opinion evidence supports a finding of total disability.

Other evidence. There is additional medical evidence consisting of hospital and medical records. (DX 33).

The following hospital and/or medical records were included in the newly submitted evidence:

- CT Scan from Johnston Memorial Hospital dated 2/5/00
- Chest PA Lateral Report from Johnston Memorial Hospital dated 6/21/00
- PA and Lateral Chest Report from Bristol Regional Medical Center dated 5/29/1998
- Progress Note from Dr. Chang dated 3/1/2000
- Office Notes from Dr. Wallace dated from 8/14/01 to 10/23/02
- An echocardiographic examination report dated 1/10/02 from Johnston Memorial Hospital

I have reviewed all of these records, and I do not find any of them to be relevant to a determination of total disability. The records contain information on the Miner's heart condition and smoking history, which is relevant to the issue of causation and the existence of pneumoconiosis. Thus, I find that the additional evidence neither supports nor disproves a finding of total disability.

Section 718.204(b)(2) as a whole. Looking at §718.204(b)(2) as a whole, I find that total disability has been established by the newly submitted evidence based upon the qualifying arterial blood gases and the medical opinions discussed above, notwithstanding the nonqualifying pulmonary function tests and other medical evidence. Based solely upon the newly submitted evidence, Claimant has established at least one condition of entitlement, the

element of total disability, and has therefore satisfied the requirement for reopening the case for review under §725.309(d).

As Claimant has established a basis for reopening the claim based upon the establishment of a totally disabling pulmonary or respiratory condition, I must proceed to the merits of the claim.

Merits of the Claim: Causation of Total Disability

Because it is closely related to the issue of total disability and the discussion of whether the Claimant's disability may be deemed to be pulmonary or respiratory, I will proceed to consideration of the disability causation issue first. In addressing this issue, I will assume, arguendo, that the Claimant suffers from clinical or legal pneumoconiosis.

After establishing that a miner is totally disabled, a claimant must still establish that the miner's total disability was caused by his or her coal mine employment. 20 C.F.R. §718.204(a). If the presumptions are not available to a claimant, that claimant must prove the etiology of the disability by a preponderance of the evidence, even if he or she has proven the existence of total disability. *See Tucker v. Director,* 10 B.L.R. 1-35, 1-41 (1987). Under the amended regulations, the finder-of-fact must not take into account any non-pulmonary or non-respiratory impairments a miner may have when making this determination, unless said condition causes a chronic respiratory or pulmonary impairment. 20 C.F.R. §718.204(a). In meeting this last requirement, a claimant must show that "pneumoconiosis . . . is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment," which means that it had a material adverse effect on the miner's respiratory or pulmonary condition or that it materially worsened a totally disabling respiratory or pulmonary impairment caused by a disease or exposure unrelated to coal mine employment. 20 C.F.R. § 718.204(c)(1).

Under the old regulations, the U.S. Court of Appeals for the Fourth Circuit held that a miner's pneumoconiosis must be at least a "contributing cause" of his or her totally disabling pulmonary impairment. *Jewell Smokeless Coal Corp. v. Street,* 42 F.3d 241 (4th Cir. 1994); *Hobbs v. Clinchfield Coal Co.,* 917 F.2d 790 (4th Cir. 1990); *Robinson v. Pickands Mathur & Co.*, 914 F.2d 35 (4th Cir. 1990). In *Robinson*, the Fourth Circuit explained, based upon the old version of the regulations, that the pneumoconiosis must be a necessary condition of a miner's disability, and if he would have been disabled to the same degree and by the same time in his life if he had never been a miner, then benefits should not be awarded.

There is a slight difference in the new regulations, which allow for a finding of total disability due to pneumoconiosis even when there is another totally disabling respiratory or pulmonary condition if pneumoconiosis has a material adverse effect or materially worsens an unrelated total respiratory or pulmonary disability. *See* 20 C.F.R. § 718.204 (2001).[5] In addition, the new regulations place an additional burden upon the Claimant to establish a

[5] As noted above, in *National Mining Assn. v. Dept. of Labor*, 292 F.3d. 849 (D.C. Cir. 2002), the U.S. Court of Appeals for the D.C. Circuit found the portion of 20 C.F.R. § 718.204(a) providing that unrelated nonpulmonary or nonrespiratory conditions causing disability will not be considered in determining whether a miner is totally disabled due to pneumoconiosis to be impermissibly retroactive. The section was otherwise upheld.

substantial contribution by pneumoconiosis. In this regard, the Department's comment in the preamble to the regulations that "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. 79,946 (Dec. 20, 2000).

The Benefits Review Board had an opportunity to examine this new provision in *Gross v. Dominion Coal Corp.*, BRB No. 03-0118 BLA (Benefits Review Board, Oct. 29, 2003) (to be published).[6] In that decision (slip op. at 6 to 7), the Board held that an opinion (by Dr. Forehand) stating that pneumoconiosis was one of two causes of the miner's totally disabling pulmonary condition, but which did not attempt to specify the relative contributions of coal dust exposure and cigarette smoking, was sufficient to satisfy the new standard. The Board found that the doctor's opinion satisfied that "material adverse effect" requirement. The Board also found that substantial evidence supported the administrative law judge's discrediting of the opinion offered by the employer's expert (Dr. Castle) under *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), which held that an administrative law judge should consider the explanation provided by an expert offering an opinion.

The same four medical opinions discussed above on the issue of total disability, by Drs. Forehand, Hippensteel, Rasmussen, and McSharry, are also relevant on the causation issue. I have recounted the opinions of these physicians in some detail above. Dr. Forehand attributed the Claimant's resting hypoxemia to unspecified factors besides pneumoconiosis but found the respiratory impairment to be attributable to CWP. However, his opinion is entitled to less weight because he was unable to review more recent data and his opinion was stated in a conclusory manner. The opinion he rendered in connection with the previous (1999) claim suffers from the same deficiencies, but he reached different conclusions at that time, finding the Claimant to be totally disabled due to a combination of chronic bronchitis and CWP. Dr. Hippensteel stated that Claimant's gas exchange impairment did not appear to be associated with a pulmonary or respiratory disability and he attributed it to the Claimant's cardiovascular system. He pointed to the diffusion capacity (which was reduced but in the normal range) and the pulmonary function test results (which showed only mild, nondisabling impairment) as tending to exclude coal mine employment as a potential cause. He explained his findings in detail at his deposition. Dr. McSharry did not find the hypoxemia to be explained by any known cardiac or pulmonary abnormalities, but he essentially agreed with Dr. Hippensteel that the pulmonary function and diffusion findings, coupled with the abnormal blood gases that worsened with exercise, indicated that coal mine dust was not the cause. He also explained his findings at his deposition. Dr. Rasmussen opined that both cigarette smoking and coal dust exposure contributed to the impairment but that the Claimant's coal mine dust exposure was the major cause of his disabling lung disease. This opinion would be sufficient under *Gross, supra.* However, Dr. Rasmussen did not explain in any detail the basis for his conclusions and his report lacks analysis. After consideration of all of this evidence, I find the opinion of Dr. McSharry to be the best reasoned and to outweigh Dr. Rasmussen's fairly conclusory opinion. Further, I find it to be corroborated by the opinion of Dr. Hippensteel. In view of the deficiencies in Dr. Forehand's opinion, due to his inability to review the more recent arterial blood gases and his failure to explain his

[6] The decision is available on the BRB website, which may be accessed via a link from the OALJ website, www.oalj.dol.gov.

conclusions, I do not find it to undermine Dr. McSharry's conclusions. None of the other evidence of record supports a finding that Claimant's disability was due to pneumoconiosis. Accordingly, I find that the Claimant has failed to establish disability causation.

CONCLUSION

As the Claimant has established total disability through the newly submitted evidence, the claim will not be denied under section 725.309 and instead has been considered on the merits. However, this claim fails when considered on its merits because a requisite condition of entitlement -- causation of total disability -- has not been established. A separate discussion and analysis of the remaining issues raised in this claim is therefore unnecessary.

ORDER

IT IS HEREBY ORDERED that the claim of Orland Parks for black lung benefits be, and hereby is, **DENIED.**

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PAMELA LAKES WOOD
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.